

their child. The child is having acute breathing, and you do not know if that child is having an undetected asthma attack; or a man sitting at Oriole Park suddenly has shortness of breath, pains in his left side and leaves to go to the ER at the University of Maryland next to Camden Yards. Should they call 911 or should they call 800 HMO? I think they should call 911, and they should worry about themselves and their family and not about reimbursement.

So when we come to a vote, I really hope that we will pass the Graham amendment. The Republicans say they have an alternative. But it does not guarantee that a patient can go to the closest emergency room without financial penalty. Do not forget, it covers only 48 million Americans; it leaves out 113 million other Americans.

Let's do the right thing. Let's make sure that patients with insurance cannot be saddled with huge bills after emergency treatment.

I thank the Senate and yield the floor.

The PRESIDING OFFICER. The time of the Senator has expired.

#### CONCLUSION OF MORNING BUSINESS

The PRESIDING OFFICER. Morning business is closed.

#### PATIENTS' BILL OF RIGHTS ACT OF 1999

The PRESIDING OFFICER. The Senate will now resume consideration of S. 1344, which the clerk will report.

The assistant legislative clerk read as follows:

A bill (S. 1344) to amend the Public Health Service Act, the Employee Retirement Income Security Act of 1974, and the Internal Revenue Code of 1986 to protect consumers in managed care plans and other health coverage.

Pending:

Daschle amendment No. 1232, in the nature of a substitute.

Daschle (for Kennedy) amendment No. 1233 (to Amendment No. 1232), to ensure that the protections provided for in the Patients' Bill of Rights apply to all patients with private health insurance.

Nickles (for Santorum) amendment No. 1234 (to Amendment No. 1233), to do no harm to Americans' health care coverage, and expand health care coverage in America.

Graham amendment No. 1235 (to amendment No. 1233), to provide for coverage of emergency medical care.

Mr. FRIST addressed the Chair.

The PRESIDING OFFICER. The Senator from Tennessee.

#### AMENDMENT NO. 1235

Mr. FRIST. Mr. President, I understand we are currently on the Graham amendment. Could you tell us how much time remains on either side?

The PRESIDING OFFICER. There are 33 minutes 8 seconds for the majority; and 7 minutes 59 seconds for the minority.

Mr. FRIST. Thank you.

Mr. President, today we will be talking about a number of issues that have

to do with the Patients' Bill of Rights. Yesterday, the discussions began on what I regard as a very significant, important piece of legislation that is called the Patients' Bill of Rights. The debates that we will be having on the floor address really two underlying bills that were introduced formally yesterday: One is the Kennedy bill from the Democratic side, and the other is the Republican leadership bill. Both bills set out to accomplish what I think we all absolutely must keep in mind as we go through this process, and that is to make sure that we are focusing on the patients in improving the quality and the access of care for those patients and at the same time help this pendulum swing back to where patients and doctors are empowered once again; not to have this be so much in favor of managed care that, when it comes down to an individual patient versus managed care on certain issues, managed care enters into this realm of practicing medicine.

Again, I think if we keep coming back to focusing on the individual patient, we are going to end up with a very good bill.

We left off last night with the discussion of the Graham amendment which focuses on emergency services. In the Republican bill, basically there are a list of patient protections which include a prohibition of gag clauses, access to medical specialists, access to an emergency room, which is the real thrust of the Graham amendment, continuity of care—a range of issues that we call patient protections.

A second very important part of our bill focuses on quality and how we can improve quality for all Americans. I am very excited about that aspect of the bill. We will be discussing that later this week. That is our responsibility as the Federal Government, to invest in figuring out what good quality of care actually is. It is similar to investing in the National Institutes of Health: The research behind determining where the quality is, and spreading that information around the country so that excellent quality can be practiced and people can have access to that.

A third component of the Republican bill which I think is, again, very important that we will keep coming back to, is the access issue, the problem of 43 million people in this country who are uninsured. Some people say: No, that is a separate issue; we can put it off for another day.

But when you look at patient protections, you look at quality and you look at access. It is almost like a triangle. If you push patient protections too far you end up hurting access. If you push issues beyond what is necessary, to get that balance between coordinated care and managed care and fee for service and individual physicians' and patients' rights, if you get too far out of kilter, all of a sudden premiums go sky-high.

When premiums go sky-high in the private sector, employers, small em-

ployers start dropping that insurance. It becomes too expensive for an individual to go out and purchase a policy, and therefore instead of having 43 million uninsured, you will have 44 million, 45 million, or 46 million, all of which is totally unacceptable. As trustees to the American people, we simply cannot let that happen. Therefore, you will hear this quality and access and patient protection discussion go on over the course of the week.

Last night and today over the next 45 minutes or so we will be focusing on this patient access to emergency medical care. Let me just say that I have had the opportunity to work in emergency rooms in Massachusetts for years, in California on and off for about a year and a half, in Tennessee for about 6 years, and almost a year in Southampton, England.

Whether it is a laceration, whether it is a sore throat, whether it is chest pain, whether it is cardiogenic shock from a heart attack, access to emergency room care is critically important to all Americans.

We have certain Federal legislation which guarantees that access, but it is clear there are certain barriers that are felt today by individuals that their managed care plan is not going to allow them to go to a certain emergency room or, once they go, those services are not covered. That is the gist of what we have in the Republican bill—a very strong provision for patient access to emergency medical care.

This Republican provision, as reported out of the Health, Education, Labor, and Pension Committee where this was debated several months ago, requires group health plans, covered by the scope of our bill, to pay, without any prior authorization, for an emergency medical screening exam and stabilization of whatever that problem is—whether it is cardiogenic shock, whether it is a laceration or a broken bone or falling down the steps or a broken hip—to pay for that screening and that stabilization process with no questions asked—no authorization, no preauthorization, whether you are in the network or outside of the network.

The prudent layperson standard is very important for people to understand. The prudent layperson standard is at the heart of the Republican bill. We use the words "prudent layperson." By prudent layperson, we define it as an individual who has an average knowledge of health and medicine. The example I have used before is, if you have a feeling in your chest, and you do not know if it is a heart attack or indigestion, and you go to the emergency room, a prudent layperson, an average person, would go to the emergency room in the event that that was a heart attack, and therefore is the standard that is at the heart of the Republican bill. Now, there are two issues that need to be addressed. We talked about them a little bit yesterday. One is what happens with the

poststabilization period. You are at home. You have this feeling in your chest. You go to the emergency room. Under our bill, you are screened; you are examined. Initial treatment stabilization of that condition is given.

Then the question is, What happens with poststabilization? This is where I have great concern in terms of what my colleague from Florida has proposed and what is in the underlying Kennedy bill. That is, once you get in the door, you can't open that door so widely that any condition is taken care of out of network. Why? Because it blows open the whole idea of having coordinated care, having a more managed approach to the delivery of health care.

This is a huge door you could get into. Then, once you get into that hospital door, you might say: Well, I have a little ache over here. Can you examine that and put me through all the diagnostic tests, regardless of what my health plan says and what I have contracted with my health plan to do?

That is where the concern is. The issue of poststabilization needs to be addressed; we need to talk more about it. Over the course of last night and, actually, the last several weeks, we have worked very hard to look at that poststabilization period. In just a minute, I will turn the floor over to my colleague from Arkansas to talk more about that.

The other issue is on cost sharing. We need to make sure there is no barrier there that would prevent somebody going to the closest emergency room or the emergency room of choice. It is an issue, I believe, we, as a body, Democrat and Republican, are obligated to address, to make sure that barrier is not there—again, returning to the patient so if the patient has any question at all, they don't have to think about payment and barriers and will they turn me away or, once I get in the emergency room, will they refuse to treat, but basically can I get the necessary care.

That is what is in the Republican bill. I am very proud of that. Can it be improved? Let's discuss it and see if there is anything we can do to make it better.

That is where we were yesterday, and that is where we are this morning. We will have a number of amendments as we go forward. Right now we are on the Graham amendment on emergency services.

At this juncture, on the amendment, I yield the time necessary to the Senator from Arkansas.

The PRESIDING OFFICER. The Senator from Arkansas.

Mr. HUTCHINSON. I thank my colleague, the distinguished Senator from Tennessee. I express not only my appreciation but the appreciation of all Senators for the expertise that Senator FRIST brings to this important issue, as well as the care and compassion he has demonstrated throughout his career, even during his time in the Senate, in caring for other people in emergencies.

He certainly brings a great deal of personal experience and expertise to this issue.

I rise to speak on this issue of access to emergency services and to explain why I believe my colleagues should oppose the Graham amendment. The amendment tree to which the Graham amendment was filed is now full. I alert my colleagues to an amendment I will be offering further along in the debate—I have been assured of the opportunity to do that—which will address the concerns raised by Senator Graham but, I think, addresses them in a far more responsible way.

Mr. GRAMM. That is GRAHAM of Florida.

Mr. HUTCHINSON. The Senator from Texas asks for that clarification.

I ask my colleagues to oppose the amendment by Senator GRAHAM of Florida, knowing they will have an opportunity to vote for a clarification amendment dealing with emergency services later on.

My amendment will remove the ambiguity that I think is so evident in the Graham amendment which will create such problems. The Republican provision, as reported out of the HELP Committee, requires group health plans covered by the scope of our bill to pay, without prior authorization, for an emergency medical screening exam and any additional emergency care required to stabilize the emergency condition for an individual who has sought emergency medical services as a prudent layperson.

As I listened to the comments of the distinguished Senator from Maryland, it is clear that what the Republican bill does and what my amendment will do needs clarification for my colleagues, because Jackie, the example that was given, would be covered, very clearly. The prior authorization issue is clearly covered. The closest emergency room issue is covered. The prudent layperson definition is repeatedly used.

Prudent layperson is defined as an individual who possesses an average knowledge of health and medicine. The purpose of this provision is to ensure that a person who has a reason to believe they are experiencing an emergency, according to the prudent layperson standard, will not, cannot, be denied coverage. If they are diagnosed with heartburn instead of a heart attack, they are still going to be covered under the prudent layperson definition.

In addition, by eliminating the requirement for prior authorization, no prior authorization will be required. Jackie doesn't have to make a phone call while she is unconscious; no one has to make a phone call asking for prior authorization. We ensure that individuals can go to the nearest emergency facility.

On the issue of cost sharing, plans may impose cost sharing on emergency services, but the cost-sharing requirement cannot be greater for out-of-net-

work emergency services than they require for in-network services.

Mr. GRAHAM. Will the Senator yield for a question?

Mr. HUTCHINSON. I will be glad to yield when I conclude my comments. Let me go ahead because I think I may answer many of those questions as I go through.

An individual who has sought emergency services from a nonparticipating provider cannot be held liable for charges beyond what that individual would have paid for services from a participating provider.

Senator ENZI and I offered an amendment to this effect in the committee, and it was adopted by the committee. That amendment and the provision that is in the underlying Republican bill says that if a group health plan, other than a fully insured group health plan, provides any benefits with respect to emergency medical care as defined in subsection (c), the plan shall cover emergency medical care under the plan in a manner so that if such care is provided to a participant or beneficiary by a nonparticipating health care provider, the participant or beneficiary is not liable for amounts that exceed the amounts of liability that would be incurred if the services were provided by a participating provider. It is not going to cost the patient more if they go to a nonparticipating provider in that emergency room than they would if they went to one that was within their network.

As I think was pointed out by my colleague, Senator FRIST, and Senator GRAHAM of Florida last evening, the committee report language needs clarification on the committee's intention on cost sharing for in- and out-of-network emergency services. My amendment will certainly make that clarification.

My amendment will also improve the access to emergency services provision reported by the HELP Committee by requiring the plan to pay for necessary care provided in the emergency room to maintain medical stability following the stabilization of an emergency medical condition until the plan contacts the nonparticipating provider to arrange for transfer or discharge. If the plan fails to respond within a very narrow, specific time period, the plan is responsible for necessary stabilizing care in any setting, including in-patient admission.

We clearly state in the amendment which I will offer that these stabilizing services must be directly related to the emergency condition that has been stabilized. I think this was the point Senator FRIST made so very eloquently: If you do not make that connection, if you do not have the requirement that it has to be related to the emergency condition that has been stabilized, then you truly have a loophole. You open the door that totally undermines the concept of coordinated care.

To understand the true impact of the Republican access to emergency services provision as clarified and improved

by my amendment, let me offer the following scenarios and show how they are addressed by our provision in the bill.

Several examples have been repeated a number of times by my colleagues across the aisle. Let me use their examples. They specifically mentioned the case of a mother with a febrile child who called her health plan before going to the emergency room and was required to go to an in-network emergency facility, passing several nearby facilities on the way. Her child, tragically, had a serious infection which, due to the delay in care, resulted in amputation. There were very moving pictures of this particular child. Under our bill, a mother with a sick child will be able to access the closest emergency room, and she won't get stuck with the bill because she did not get prior authorization.

In a case referred to by my colleague from North Dakota, Senator DORGAN, if someone has taken a 40-foot fall and has been helicoptered to a hospital and delivered to an emergency room in a state of unconsciousness with fractured bones in three parts of her body, does that person have a right to emergency care under the Republican bill? The answer is yes, because we eliminate the prior authorization requirement. The case cited by my colleague from Montana, Mr. BAUCUS, where a woman came into an emergency room after falling and sustaining a complex fracture to her elbow, and the emergency physician diagnosed the problem and stabilized the patient. The stabilization process took less than 2 hours, but the patient's stay in the emergency room lasted for another 10 hours while the staff attempted to coordinate the care with the patient's health plan. The plan was unable to make a timely decision.

Under the Republican bill, the woman in this case will not have to wait hours on end for a response from her health plan. Under our provision, as improved by my amendment, the health plan must respond to the nonparticipating provider within a specific timeframe to arrange for further care.

Under the Democrats' bill, plans are required to pay, without prior authorization, for emergency services and "maintenance and post stabilization services as defined by HCFA [Health Care Financing Administration] and Federal regulations to implement the Balanced Budget Act of 1997." I believe this is where the Democrat provision goes wrong and, quite frankly, it shows where we can make a much-needed improvement to the Balanced Budget Act language.

In the September 28th Federal Register, Volume 63, HCFA defines poststabilization as "medically necessary, nonemergency services furnished to an enrollee after he or she is stabilized following an emergency medical condition."

Now, that definition is completely vague and completely open-ended. I

think it would be a serious mistake to take that language and to transport it into this very important bill.

Under this definition, a plan could conceivably be required to pay for services by a nonparticipating provider that are completely unrelated to the emergency conditions for which that patient was treated. To go in for one particular emergency, and while you are in that poststabilization period, to say: By the way, I also have a problem here and here; can you deal with that? And then require the plan to cover it, I think that would be a very serious mistake. The confusion and the ambiguity in the language is further perpetuated by conflicting statements on the meaning of "poststabilization" found in other places in the regulations.

So my amendment will provide for timely coordination of care. It ensures that the patient will receive the appropriate stabilizing services related to their emergency medical condition. The prudent layperson standard assures that a plan cannot retrospectively deny coverage for an event that was felt to be an emergency medical condition at the time the individual sought emergency care. It eliminates the prior authorization requirement so an individual can go to the nearest emergency facility and not have to worry about whether they are going to be covered if they go to a nonparticipating provider and that they might get stuck with the bill.

While my colleagues say they are simply adopting what was passed under Medicare, it is my contention that the provision I am offering will be an improvement on what is in Medicare because of the open-endedness and ambiguity of the language. I suggest that at some point we are going to have to revisit the Medicare provision and improve it as well.

In the meantime, I urge my colleagues to oppose the Graham of Florida emergency room amendment and vote for the amendment I will be offering later in the debate. Since this amendment tree is now full, I will have to offer that at a later point.

Mr. GRAHAM. Will the Senator from Arkansas yield?

Mr. HUTCHINSON. I will be glad to yield if I can yield on your time. We have limited time remaining on our side.

Mr. GRAHAM. I will try to ask short questions, and I will appreciate short answers.

One, you signed the committee report which, on page 29, says the committee believes it would be acceptable to have a differential cost sharing for in-network and out-of-network emergency charges. Are you saying that statement of explanation of the bill is incorrect?

Mr. HUTCHINSON. I believe that needs to be clarified, and my amendment will do that.

Mr. GRAHAM. When will you submit the language that will clarify what the committee report states?

Mr. HUTCHINSON. I will be glad to do that this morning.

Mr. GRAHAM. Two, with reference to poststabilization, what the current law for Medicare requires, and what this would require, is that the emergency room call the HMO and request the HMO's authorization as to what treatment to provide in the poststabilization environment. It is only when the HMO is unresponsive—in the case of Medicare, within 1 hour. If they fail to respond, then the emergency room has the right to do what it thinks is medically necessary for the patient.

Now, did the committee hear any testimony that there had been major abuses under the Medicare 1-hour-respond-to-call standard?

Mr. HUTCHINSON. What I suggest to the Senator is that my amendment will make that same requirement, only that the poststabilization services have to be related to the emergency room event.

Mr. GRAHAM. The question is, Was there any testimony to the kinds of abuses you have outlined under the current Medicare law?

Mr. HUTCHINSON. I am not certain at this point.

Mr. GRAHAM. Did the committee hold hearings on this bill, and did they not ask anybody what has happened under the 2½ years of experience we have had with Medicare and Medicaid?

Mr. HUTCHINSON. I say to the Senator from Florida that, in fact, there are abuses, I believe—

Mr. GRAHAM. Can the opponents of this amendment put into evidence before the full Senate and the American people what those abuses have been? We have had 2½ years of experience, covering 70 million Americans. If there have been abuses, they ought to be available and not just speculated about.

Mr. HUTCHINSON. In responding to the Senator, if there are no abuses, there should be no concern about clarifying language to ensure that, in fact, poststabilization treatment is related to the emergency room event. That is what I believe needs to be done. I think whether or not we can point to specific abuses in Medicare or not, the ambiguity in the language in Medicare is open to those kinds of abuses, and we will certainly see that occur if it is expanded to all managed care plans in the country. We certainly need to clarify that and ensure that the poststabilizations are related to the emergency room event.

Mr. GRAHAM. Let me go to a third issue. I discussed this yesterday. In the Republican bill, it states that while the person is stretched out in the emergency room under tremendous physical and emotional stress, they have the responsibility of monitoring the emergency room physician to determine if the type of diagnosis that the emergency room physician is rendering is appropriate. Could you explain how a person in an emergency room circumstance is supposed to provide that

kind of second-guessing of an emergency room physician?

Mr. HUTCHINSON. To the extent that the word "appropriate" should be removed, our amendment will, in fact, remove that. I don't believe that is an accurate reflection of what the Republican underlying bill would do.

Mr. GRAHAM. That is another defect. The use of the word "appropriate" is a gaping loophole.

Mr. HUTCHINSON. And which will be removed and clarified.

Mr. GRAHAM. I am concerned about the further provision which says that the patient is responsible for second-guessing the appropriateness of care rendered by the emergency room physician. Is that going to be taken care of?

Mr. HUTCHINSON. I do not believe that is an accurate reflection of that provision.

Mr. GRAHAM. I suggest that the Senator might read the bill and see that it is precisely what the bill says. I am concerned because we had a discussion last night with Dr. FRIST, and now today, which indicates that the Republican proposal has a number of admitted inconsistencies, inaccuracies, and gaping holes. Rather than us relying upon an amendment nobody has seen that is supposed to rectify those, why don't we vote for the Democratic amendment that would solve these problems?

Mr. HUTCHINSON. I think I have very clearly outlined what my amendment will do, and I have expressed very clearly my concerns about the Graham of Florida amendment. I will read right now, if you would like, the entire summary of the amendment and what it would do. I think it will respond to the concerns that many of my colleagues on the other side simply have misrepresented. What you call "gaping holes" simply need clarification, which my amendment will do. It will address it in a much more rational and responsible way than the very ambiguous language that I believe the Graham amendment contains.

Mr. GRAHAM. Well, I just offer a conclusion—not a question but a statement of fact. We have had 2½ years of experience with 70 million Americans. Our proposal will be available to all Americans in the instances of rampant abuse. I think it is incumbent upon those who make these charges to document it rather than just pontificate.

Mr. HUTCHINSON. Reclaiming my time. I reserve the remainder of my time.

Mr. REID. Mr. President, I yield 4 minutes to the Senator from North Dakota.

The PRESIDING OFFICER. The Senator from North Dakota is recognized.

PRIVILEGE OF THE FLOOR

Mr. DORGAN. I ask unanimous consent that Mina Addo, Leah Palmer, Jana Linderman, and Deborah Garcia be given floor privileges today.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. DORGAN. Mr. President, yesterday I described a case dealing with

emergency rooms which I understand my colleague referred to in his remarks. I want to go back to that case because I think it describes the difference between our two proposals with respect to protections for emergency room treatment for patients.

I described the case of little Jimmy Adams. This is a picture of Jimmy. This is a picture of a young, healthy Jimmy tugging on his big sister's shirt.

Here is a picture of Jimmy Adams after he lost both his hands and both his feet because he couldn't get care at the closest emergency room.

This is what happened. He was sick with a 104 degree fever. His mother called the family HMO. Officials there said you must go to a certain hospital in our network. So his parents loaded Jimmy up at 2 o'clock or so in the morning and started driving. They had to drive past the first hospital, the second hospital, and then drove past the third hospital. Finally they got to the hospital the HMO asked them to take Jimmy to. By that time, Jimmy's heart had stopped. They brought out the crash cart, intubated, and revived him. Regrettably, however, he suffered gangrene, and his hands and his feet had to be amputated.

Why didn't they stop at the first emergency room? Because they couldn't; the HMO said they won't pay for that. Why didn't they stop at the second hospital emergency room or the third? The HMO won't fully pay for that care. So they drove over an hour with a young, sick child who, because he didn't get medical treatment in time, lost his hands and his feet.

Now, my colleague says the Republican plan will solve little Jimmy's situation. Regrettably, it will not. Yes, the Republican plan will provide that that family could stop at that first hospital for emergency care, but it also allows the HMO to penalize the family financially for doing so. It allows the HMO to establish a financial penalty for this family to stop at out-of-network hospitals.

If their bill doesn't do that, I want to see it. As I read the Republican proposal, they say: We have protections here.

In fact, they don't have protections. In virtually every area of the two proposals on managed care, we see exactly the same thing. They have an emergency room provision. Is it better than currently exists? Yes, it is better. Does it solve the problem? No. This family would have been told: If you stop at the first emergency room with Jimmy, we will impose a penalty upon you. We have the right to impose a financial penalty for going to the nearest hospital emergency room.

If the other side wants to prevent that, I say, join us in supporting the Graham amendment, because we prevent that. We provide real protection for families with respect to emergency room treatment. Our amendment won't allow an HMO to say: Take that sick child to an emergency room but, by the

way, you have to go to an emergency room four hospitals; if you stop sooner than that, we will penalize you.

That doesn't make any sense to me.

This issue is not about theory. It is about real people like Jimmy. It is about what the two pieces of legislation say regarding patient protection. My colleague from Florida, Senator GRAHAM, described the differences between the two bills on emergency care. He asked the questions and didn't get the answers, because satisfactory answers don't exist with respect to our opponents' proposal. Their proposal is, in fact, a shell. It does not offer the protections that we are offering in the proposal before the Senate.

Mr. MURRAY. Mr. President, I am pleased to join with Senator GRAHAM in support of access to emergency room care. During consideration of a Patients' Bill Rights in the Health, Education, Labor and Pensions Committee, I offered a similar amendment in an effort to prevent insurance companies from denying access to life saving emergency care. Unfortunately, my amendment was defeated on a straight party line vote.

I had offered the amendment because of problems that I have heard from emergency room doctors and administrators about creative ways insurance companies seek to deny access to emergency care. I offered the amendment because I have seen in my own state of Washington the inadequacy of simply saying care is provided if a prudent lay person deems it an emergency. We have a prudent lay person standard in the State yet we have seen where patients are turned away and reimbursement is denied.

The big flaw with the Republican bill regarding emergency room care is the lack of coverage of poststabilization care. This is the key different between our bill and that offered by the Republican leadership. We recognize the importance of not only administering emergency services but stabilizing the patient as well.

Let me give my colleagues an example of the importance of poststabilization care; you rush your sick child to the emergency room with a fever close to 105. The fever escalates quickly and without warning. The emergency room doctors and nurses are able to control the fever and stabilize the child, but are concerned about determining the cause of the fever. They recommend poststabilization treatment to determine what caused the child to become so ill so quickly. The insurance company denies this treatment and the parents are told to take their child home and hope to get into see their own primary care physician the next day. Later that evening the child's fever escalates and the child begins to have seizures as a result. The child is then admitted to the hospital for more expensive acute care.

Why was follow-up poststabilization care not provided? What are the long-term effects on the child? Did the insurance company save a dime of the

premium paid by hard working Americans? No, in fact their callous behavior resulted in additional costs that could have been prevented.

I cannot imagine anything more frightening than holding a child who is experiencing uncontrollable seizures because their tiny body could not endure the impact of a high raging fever. Poststabilization is essential.

I urge any of my colleagues who think the Republican bill is sufficient to talk to ER doctors and nurses. Ask them how a patient is treated when brought into the ER. Let me give you another example that was discovered by the insurance commissioner's office in Washington state:

A 17-year-old victim of a beating suffered serious head injuries and was taken to an emergency room. A CAT scan ordered by an ER physician was rejected by the insurance company because there was no prior authorization for this test. In other words, we can stabilize the patient, but cannot do any post stabilization treatment to determine the extent of the injuries without seeking authorization from an insurance company hundreds of miles away.

Another example, in a state with a prudent lay person standard: The insurance commissioner's office found that an insurance company denied ER coverage for a 15-year-old child who was taken to the emergency room with a broken leg. The claim was denied by the insurer as they ruled the circumstances did not constitute an emergency. This is outrageous. A broken leg is not an emergency? By any standard, prudent lay person or medical standard, treatment of a broken leg would be considered an emergency.

I use these examples of real people and real cases to illustrate the flaws in the Republican bill. You can say you cover emergency room care and you can keep saying it hoping that it is true. But, unfortunately, the Republican bill does not provide adequate emergency room coverage.

I was disappointed in the HELP Committee markup when my amendment was defeated. I had truly hoped that we could reach a bipartisan agreement on emergency room care coverage. I had seen that we could reach a bipartisan agreement when it came to Medicare and Medicaid beneficiaries. We approved these very same provisions for these beneficiaries during consideration of the Balanced Budget Act of 1997. I had assumed that we would give the same protections to all insured Americans. It was a priority in 1997 and should be a priority in 1999.

We have spent a great deal of public and private resources to build an emergency health care and trauma care infrastructure that is the envy of the world. This infrastructure has saved millions of lives and provides a standard of care that is hard to beat. Yet policies focusing on restricting access to this care threaten the very infrastructure of which we are so proud. The ER doctor must be the one to admin-

ister care without fear of insurance company retaliation.

I urge my colleagues to support this amendment to provide 160 million insured Americans with access to state-of-the-art emergency room and trauma care. Please do not close the emergency room doors on these families.

Mr. HUTCHINSON. Mr. President, I inquire as to how much time remains on each side.

The PRESIDING OFFICER. The Senator has 10 minutes 43 seconds. The time has expired for the minority.

Mr. HUTCHINSON. Mr. President, I will make a couple of clarifications. I am puzzled by the reference to a penalty, the allegation, the insinuation, that the Republican bill somehow would allow a penalty to be charged.

S. 326 as reported by the committee requires plans to pay for screening and stabilizing emergency care under the prudent layperson standard without prior authorization, and the plan cannot impose cost sharing for out-of-network emergency care that would exceed the amount of cost sharing for similar in-network services. There is no differential. There can be no penalty charged under the Republican bill.

The amendment I will offer requires that the plans must pay for emergency services required. To maintain the medical stability in the emergency department plan, the plan contacts the nonparticipating provider to arrange for discharge of transfer. If the plan does not respond—as under Medicare, does not respond—to authorization of a request within a set time period, the plan must pay for services required to maintain stability in any setting, including an inpatient admission.

The great difference is that under the language of the Graham of Florida amendment, the emergency room could be required to not only provide services unrelated to the emergency event but that the health insurance plan would then be required to pay for and reimburse.

It is a glaring ambiguity. It in fact is the gaping hole in the language, and it is that which needs to be rejected. I will ask my colleagues to oppose the Graham of Florida amendment because of that ambiguity of language. Simply taking language from the Medicare balanced budget amendment, transporting that into this without any concern for the poorly defined ambiguous language that is used, I think my colleagues—

Mr. GRAHAM. Will the Senator yield?

Mr. HUTCHINSON. I think I have yielded quite enough. We have used quite a bit of our time in yielding.

I think it is very difficult to argue that treatment in an emergency room should be related to the emergency event. That is what we want to ensure.

We do not believe you can preserve any sense of coordinated care if you require health plans to pay for, in the poststabilization period, medical needs totally unrelated to the emergency

that brought that patient to the emergency room.

That is sufficient for rejection of the Graham of Florida language.

I reserve the remainder of my time.

The PRESIDING OFFICER. Who yields time?

If no one yields time, the time running is the majority's time.

Mr. REID. That is because there is no time left on this side?

The PRESIDING OFFICER. That is correct.

Mr. GRAHAM. With the additional time that the majority has, would they respond to questions on their time? Would they at least cite in the bill the language that they believe is insufficient and creates an ambiguity?

Mr. NICKLES. Mr. President, I inform my colleagues, since we are on managed time, they are more than welcome to use time on the bill. They have that option, and I am sure the Senator from Nevada will yield to the Senator.

I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The legislative assistant proceeded to call the roll.

Mr. REID. I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. REID. I say to my friend, we can't have quorum calls. The time should be running so that in 10 minutes you can offer your next amendment. A quorum call is not in keeping with what we are supposed to be doing.

Mr. NICKLES. Mr. President, to respond to my colleague, we have had almost no quorum calls since the debate has begun. I am preparing to offer an amendment in a moment. That amendment will be ready.

I will suggest the absence of a quorum and send the amendment to the desk momentarily.

The PRESIDING OFFICER. The clerk will call the roll.

The legislative assistant proceeded to call the roll.

Mr. HUTCHINSON. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered. The Senator from Arkansas.

Mr. HUTCHINSON. Mr. President, I want to take just one moment to respond to the question that was posed as to our specific concern about the language in the Graham of Florida amendment. The Graham of Florida amendment adopts the Medicare language. I will quote that Medicare language, from the September 28 Federal Register, volume 63. HCFA defines poststabilization, and I quote as I did before:

... medically necessary nonemergency services furnished to an enrollee after he or she is stabilized following an emergency medical condition.

That is as vague and open-ended as any language I could conceive. It is, in

effect, a blank check for the emergency room, for the provider, for the patient. That is the language that needs clarification.

We believe the poststabilization medical services that are provided must be related to the emergency event that caused the individual to go to the emergency room. That is the clarification that is necessary. I will be delighted to once again go through the amendment summary that I will be offering, but that is a critical flaw in the Graham of Florida amendment. Because of that flaw in the language, I ask my colleagues to oppose the Graham of Florida amendment.

Mr. GRAHAM. Does the Senator from Arkansas yield? The Senator from Arkansas will not yield?

The PRESIDING OFFICER. All time has expired on the amendment. The question is on agreeing to the amendment.

The Senator from Oklahoma.

Mr. NICKLES. Mr. President, I think we have some colleagues who are out right now. It is my anticipation the majority leader will want to have the vote afterwards. If my colleague wants me to pursue it, I can send an amendment to the desk or I can ask for a quorum call and we can talk to the leaders to determine what time we want to vote.

Mr. REID. I say to my friend, I think it would be appropriate. I think there has been a general agreement as of yesterday that we would vote sometime this afternoon at the agreement of the two leaders. So I think it would be better to offer an amendment and move this matter along.

Mr. NICKLES addressed the Chair.

The PRESIDING OFFICER. The Senator from Oklahoma.

Mr. NICKLES. Mr. President, momentarily I will send an amendment to the desk. I ask consent the time be charged on this amendment.

The PRESIDING OFFICER. Without objection, it is so ordered.

#### AMENDMENT NO. 1236

(Purpose: To protect Americans from steep health care cost increases or loss of health care insurance coverage)

Mr. NICKLES. Mr. President, one of the big concerns many of us have with the underlying legislation of the so-called Kennedy bill is its cost. How much will it cost employers? How much will it cost employees? What will it cost employees in lost wages? If employers have to pay increased costs for health insurance, are they not paying their employees as much as they would pay them?

Health care costs a lot. Many of us would say health care already costs too much. It is unaffordable for millions of Americans. They would like to have it. We have 43 million uninsured Americans today. Most of those Americans, I imagine, would like to be insured but they cannot afford it. So health care already costs too much. Unfortunately, the bill proposed by Senator Kennedy and many of the Democrats would

make it worse. They would make the insurance a lot more expensive and therefore less affordable. As a result, millions of Americans would probably lose their health care insurance. We think that would be a mistake.

I said yesterday we should make sure we do no harm. We should not increase the number of uninsured. I am afraid the Kennedy bill, with its estimated increase of cost of 6.1 percent over and above the inflation already expected, would increase the number of uninsured by what is estimated to be about 1.8 million persons. That is too many. That is far too many. So the amendment I will be sending to the desk, as soon as I get a copy of it, will say we should not increase the cost of health insurance by more than 1 percent. If we do, the provisions of the bill are null and void.

Let's not do any damage. Let's make sure at the outset we say very plainly we are not going to increase the cost of health care by more than 1 percent. Let's not increase the number of uninsured by over 100,000. If we do that, we have done harm, we have done damage, we have done more damage than good.

Mr. President, I send an amendment to the desk on behalf of myself, Senator GRAMM, and Senator COLLINS, and I ask for its immediate consideration.

The PRESIDING OFFICER. The clerk will report.

The legislative assistant read as follows:

The Senator from Oklahoma [Mr. NICKLES], for himself, Mr. GRAMM, and Ms. COLLINS, proposes an amendment numbered 1236.

Mr. NICKLES. Mr. President, I ask unanimous consent that reading of the amendment be dispensed with.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendment is as follows:

At the appropriate place, insert the following:

#### SEC. \_\_\_\_ EXEMPTIONS.

(a) IN GENERAL.—Notwithstanding any other provision of this Act, the provisions of this Act shall not apply with respect to a group health plan (or health insurance coverage offered in connection with the group health plan) if the provisions of this Act for a plan year during which this Act is fully implemented result in—

(1) a greater than 1 percent increase in the cost of the group health plan's premiums for the plan year, as determined under subsection (b); or

(2) a decrease, in the plan year, of 100,000 or more in the number of individuals in the United States with private health insurance, as determined under subsection (c).

(b) EXEMPTION FOR INCREASED COST.—For purposes of subsection (a)(1), if an actuary certified in accordance with generally recognized standards of actuarial practice by a member of the American Academy of Actuaries or by another individual whom the Secretary has determined to have an equivalent level of training and expertise certifies that the application of this Act to a group health plan (or health insurance coverage offered in connection with the group health plan) will result in the increase described in subsection (a)(1) for a plan year during which this Act is fully implemented, the provisions of this Act shall not apply with respect to the group health plan (or the coverage).

(c) EXEMPTION FOR DECREASED NUMBER OF INSURED PERSONS.—For purposes of subsection (a)(2), unless the Administrator of the Health Care Financing Administration certifies, on the basis of projections by the National Association of Insurance Commissioners, that the provisions of this Act will not result in the decrease described in subsection (a)(2) for a plan year during which this Act is fully implemented, the provisions of this Act shall not apply with respect to a group health plan (or health insurance coverage offered in connection with a group health plan).

Mr. NICKLES. Mr. President, let me back up a little bit and bring our colleagues, and maybe the public, up to speed as far as where we are because, from a parliamentary procedure standpoint, this is getting maybe a little bit confusing.

The Republicans offered as the underlying vehicle the so-called Kennedy bill, S. 6, the Patients' Bill of Rights. We did it because we wanted to expose that it has a lot of expensive provisions that, frankly, need to be deleted.

The Democrats offered a substitute yesterday, the Republicans' Patients' Bill of Rights Plus that was reported out of the HELP Committee. They offered that as a substitute.

Then Senator DASCHLE, on behalf of Senator KENNEDY, offered a perfecting amendment to the substitute—"the substitute" being the Republican bill—that said that should apply in scope to all plans. The Republican plan basically applies to self-insured plans. It does not duplicate State insurance, unlike the Democrats' bill that says we do not care what the States have done; we are going to insist you do everything we have dictated. They expanded the scope. That was a first-degree perfecting amendment.

The Republicans offered a second-degree amendment yesterday to the underlying first-degree amendment of the Democrats on scope that says two things: One, we think the primary function of regulating insurance should be maintained by the States. That was in the findings of the bill. And then in the legislative language: We should expand access and coverage to health care plans.

When the Democrats were so kind as to offer the Republican bill as a substitute, they forgot to offer our tax provisions. We included one of the tax provisions which we included in our Patients' Bill of Rights Plus, and that is 100 percent deductibility for the self-employed. We will be voting on that, and that will be the first vote this afternoon. We will probably be voting on that at the conclusion of Senator SMITH's statement or shortly thereafter. I expect that votes will occur on that sometime after 3 o'clock, maybe closer to 3:30.

The Democrats then were entitled to a second-degree amendment, and Senator GRAHAM of Florida offered a second-degree amendment dealing with emergency rooms. Senator HUTCHINSON and Senator FRIST debated against that and stated they would come up

with an alternative dealing with emergency rooms. That will be voted on at some later point in the debate.

This afternoon we will have a debate on the Republican amendment dealing with 100-percent deductibility of self-employed persons, and we will have a vote on the Graham amendment dealing with the emergency room provision, and then the next amendment we will actually vote on, depending on whether or not either of these second-degree amendments is adopted, will be to the amendment tree or the side to which I just sent an amendment.

I sent an amendment to the first-degree amendment on the so-called Kennedy bill. This amendment says, whatever we do, let's not increase health care costs by more than 1 percent or increase the number of uninsured by over 100,000. It is very simple and very plain: Congress, don't do it; whatever you do, whatever mandates you are considering—and we recognize and applaud everybody for having good intentions—let's do no harm; let's not increase health care costs by more than 1 percent; let's not increase the number of uninsured by over 100,000.

If the Secretary of Health and Human Services determines that it would increase costs by that amount or increase the number of uninsured by that amount, then the underlying bill will not take effect.

Those are the basic provisions of the bill. I hope and expect all of our colleagues will support this amendment. I urge its adoption.

Mr. President, I yield the floor.

The PRESIDING OFFICER (Mr. ENZI) Who yields time?

If neither side yields time, time runs equally.

The PRESIDING OFFICER. The Chair recognizes the Senator from Nevada.

Mr. REID. Mr. President, I yield the Senator from North Dakota 5 minutes.

The PRESIDING OFFICER. The Senator from North Dakota.

Mr. DORGAN. Mr. President, I have not seen the specifics of this amendment, but I have heard the description. It is interesting to hear this discussion of costs because we already have experience on this issue. The President has implemented the Patients' Bill of Rights for the Federal Employees Health Benefits Program. This is already in place for Federal employees around the country. And we know what it costs; we don't have to guess. It costs \$1 a month. CBO says the patients' protection bill will cost \$2 a month. We know it costs \$1 a month in the Federal employees health insurance program.

The costs that are described by my friend from Oklahoma are inflated for reasons I do not understand. We know what it costs. It costs \$1 a month in the Federal health benefits program, because it is already implemented, and the Congressional Budget Office says it will cost \$2 a month for our Patients' Bill of Rights.

Let's talk about costs from a different angle for a moment. I find it interesting that, when people talk about costs, they do not talk about the costs that have been imposed upon American citizens who need health care but are denied it by their HMO even though they have paid their premiums in good faith. What about the costs imposed on this young boy who was taken past three hospitals to go to the fourth because the family's HMO would not allow him to stop at the first. What is the cost imposed on that young boy who lost his hands and feet or the young boy I described yesterday whose HMO denied him therapy because it said a 50-percent chance of walking by age 5 is a minimum benefit?

Or let's talk about other costs, costs on the HMO side.

Let me read a table of the 25 highest paid HMO executives. I wonder if there is any interest or concern about their salaries while we are withholding treatment for people under the aegis of cost cutting. Let me list some of the 25 highest paid CEO executives.

Annual compensation, 1997: one CEO makes \$30.7 million, another has a \$12 million salary, a \$8.6 million salary, a \$7.3 million salary, a \$6.9 million salary—these are annual salaries—\$5.7 million, \$5.3 million, \$5.2 million, \$5.1 million, all the way down the list of the 25 highest salaries.

Mr. REID. Will the Senator yield?

Mr. DORGAN. I will be happy to yield.

Mr. REID. The Senator from North Dakota has talked about the salaries these executives make. Mr. President, he has not included the value of their stock, has he?

Mr. DORGAN. I have not. I have that on the next page. Let me describe that, starting at the top. Twenty-five companies: \$61 million in unexercised stock options, on top of the salary, for one person in 1997, \$32.7 million, \$19.9 million, \$19.0 million, \$17 million—all the way down the list of 25.

It is interesting when people talk about costs. Is there any interest in this, any interest in talking about \$35 million, \$37 million, \$38 million in unrealized stock options?

Mr. REID. Will the Senator yield for a question?

Mr. DORGAN. I will be happy to yield.

Mr. REID. Will the Senator add the stock options for that one individual and find out what it comes out to per year?

Mr. DORGAN. I do not have it listed quite that way, but I can tell my colleague that the average compensation plus stock options for these 25 executives is \$16.7 million.

Mr. REID. It is fair to say it is a huge amount of money; isn't that true?

Mr. DORGAN. Oh, yes. One of them, for example, makes well over \$30 million. Another is over \$40 million. Of course that is a substantial amount of money.

The only point I am making is this: There is a lot of money and a lot of

profit in this system. This has a lot to do with profits in for-profit medicine. On the other side, on the counterbalance, is the care for patients. Some people objected yesterday because we cited examples of patients who have been mistreated. They said this debate is not about individual patients. Of course it is. That is exactly what it is about. This debate is not about theory, it is about what kind of health care patients are going to get when they need it.

When your child is sick, what kind of treatment is your child going to get? Or if your spouse has breast cancer and your employer changes HMO plans, will someone say—I ask for 1 additional minute by consent—you cannot keep your same oncologist, you have to change doctors, even though you are in the midst of treatment? If your child needs to go to an emergency room, will someone say: We're sorry, you can't go to the one 2 miles away, you must go to the one 20 miles away? These are the kinds of issues, real people with real problems, that this debate is about. That is what this is about.

Every health organization in the country supports our bill. USA Today, in an editorial said: If you want a Patients' Bill of Rights from the Republican plan, you had better be patient because it doesn't provide a Patients' Bill of Rights.

There is a difference in these plans. At least we are on the right subject. But while we are on the subject of cost, let's talk a little about who is making the money here—\$30 million, \$20 million, \$15 million in annual compensation—and then you talk to us about cost. We can't afford \$1 a month to provide protection to Jimmy Adams so he can go to the nearest emergency room when he is desperately ill? Of course we can do that.

The PRESIDING OFFICER. The time has expired.

Ms. COLLINS addressed the Chair.

The PRESIDING OFFICER. The Chair recognizes the Senator from Maine.

Who yields time?

Ms. COLLINS. I yield myself such time on this amendment as I may consume.

Mr. President, this amendment goes to the heart of this debate. All of us agree HMOs must be held accountable for providing the care that they have promised. All of us agree we need a strong appeals process so that anyone who is denied medical treatment or medical care has an avenue that is cost free, expeditious, and easy to appeal an adverse decision from an HMO. That is not what this debate is about.

The debate is whether we solve these problems in a way that is going to cause health insurance premiums to soar, thus jeopardizing the health insurance coverage of millions of Americans, or are we going to take the approach that the HELP Committee bill takes, which is to address these problems in a way that is sensible and that

addresses the concerns about quality, about unfair denial of care, without imposing such onerous and expensive Federal regulations that we drive up the cost of health insurance and cause some people to lose their coverage altogether.

That is the heart of this debate. That is the key difference between the bill advocated by my colleagues on the Democratic side of the aisle and the bill which we support.

This amendment is simple; it is straightforward. What this amendment says is, if the Kennedy bill, in fact, increases the cost of health insurance along the lines projected by the independent Congressional Budget Office, then it would be essentially no longer in effect for group health plans.

This is an important amendment. It recognizes that cost is the single biggest obstacle to providing health insurance. It addresses the issues the CBO has outlined in its report in which it warned about what would happen if the Kennedy bill goes into effect. What would happen is, under the Kennedy bill that is before us, 1.8 million Americans would most likely lose their health insurance; employers would drop coverage, particularly small businesses that may be operating on the margin already; self-employed individuals would find health insurance still further out of reach; and we would further exacerbate the problem of the growing number of uninsured in this Nation.

We have a record 43 million Americans without health insurance. We should not be increasing the number of uninsured.

So what our amendment does is very simple. It says if there is an increase in health insurance premiums beyond 1 percent, or if the number of uninsured Americans increases by more than 100,000 people, that we will take a second look, we will put a stop to the mandates that would be imposed by the Kennedy bill.

Surely, we should be able to come to an agreement that this is the right approach to take. If my colleagues on the Democratic side of the aisle believe that their bill will not have the kind of cost estimate that the independent CBO says it will have, then they should join with us in supporting this amendment because this amendment offers important safeguards.

It says the Senate should not be implementing, we should not be passing legislation that is going to drive up the cost of health insurance and further increase the number of uninsured Americans—a number that already stands far too high at 43 million people.

By contrast, the Republican approach seeks to expand, not contract, the number of Americans with insurance. We would do that, for example, by providing full deductibility for health insurance for self-employed individuals. This is a critical issue in my State of Maine where we have so many Mainers who are self-employed. Per-

haps it is in keeping with the independent Yankee spirit of the State of Maine that we do have so many people who run their own businesses. We see them everywhere. It is the small businesses on Main Street of every town in Maine. It is our lobstermen, our fishermen, our gift shop owners, our electricians, our plumbers. We see it throughout our State. It would be the most important thing that we could do to help them to afford health insurance if we made their health insurance premium fully deductible.

So we have a very clear choice. Do we want the Kennedy approach, which is going to cause health insurance premiums to soar, causing small businesses to be unable to provide coverage at all and putting health insurance further out of reach for the 43 million uninsured Americans or do we want the approach that we have proposed through the HELP Committee bill?

Our legislation addresses the very real problems that do exist with managed care. Our approach would put treatment decisions back in the hands of physicians, not insurance company accountants, not trial lawyers. But our approach strikes that critical balance. We do so not by so overloading the system that we are going to drive up costs but, rather, by putting in common-sense safeguards that will solve the problems with managed care without jeopardizing the health insurance coverage of millions of Americans.

I urge my colleagues to join, I hope in a bipartisan way, in supporting this very important amendment. It is a way for the Senate to put itself on record as recognizing that cost is the single biggest obstacle to expanded health insurance coverage. I hope we will have bipartisan support for this amendment.

I thank my colleagues and yield the floor but reserve the remainder of our time.

Mr. NICKLES addressed the Chair.

The PRESIDING OFFICER. The Chair recognizes the Senator from Oklahoma.

Mr. NICKLES. Mr. President, I want to respond just a little bit to our colleague from North Dakota who said: Well, the Democrat bill would only increase costs by \$1 a month. CBO says—I just read the CBO report. CBO does not say it. Or if my colleague would show me where it says that, I would be happy to maybe consume that page on the floor of the Senate. I don't know, but I read rather quickly. Maybe I missed it. I read fairly fast.

But the section I am looking at in CBO says—this is talking about the Patients' Bill of Rights, S. 6:

Most of the provisions would reach their full effect within the first 3 years after enactment. CBO estimates the premiums for employer-sponsored health care plans would rise by an average of 6.1 percent in the absence of any compensating changes on the part of employers.

That is 6.1 percent. The annual premium for health insurance for a family, according to Peat Marwick, in 1998,

in an employer survey, was \$5,800. And 6.1 percent of that is \$355 per year.

If you divide that by 12, it is almost \$30 a month—not \$1 a month; \$30 a month. That is not even close.

So I make mention of this. Again, I think people are entitled to their own opinion; they are not entitled to their own facts.

If CBO says this Kennedy bill only increases costs by \$1 a month, I would like to see where it is. I just read the report—April 23, 1999. It says: 6.1 percent.

That is a fairly big difference. When I am saying the cost is almost \$30 a month—\$29.50 a month—versus \$1 a month, we have a little difference. I am using CBO. Maybe my colleague from North Dakota reads it a little differently.

I think that is a rather significant difference: \$30 a month will price a lot of people out of health insurance. This additional 6-percent increase, on top of the 9-percent increase which is already projected, is going to put a lot of people in the uninsured category. We don't want to do that. We should do no harm. We shouldn't put millions of people in the uninsured category.

I refer, again, to the CBO report, because I heard my colleague from Massachusetts assert that this will only cost a family one Big Mac a month. I don't know if he is using CBO, but we are using CBO. CBO says S. 6, the Patients' Bill of Rights, the Kennedy bill, will increase health care premiums by 6.1 percent, resulting in an \$8 billion reduction in Social Security payroll taxes over the next 10 years. This is in the report. If Social Security taxes are going down by \$8 billion, that means total payroll goes down over that same period of time by \$64 billion, total payroll reduction.

Employers are going to say: Wait a minute, if you are driving up my health care costs, I can't pay you as much. I am going to pay you less or we will offset this reduction.

That is CBO. That is not the Republican organization. That is not DON NICKLES penciling it in. This is CBO, a nonpartisan group, saying there is \$64 billion in lost wages if we pass the Kennedy bill. That is a whole lot of Big Macs. That is 32 billion Big Macs, if they cost \$2 apiece. That isn't one Big Mac. As Senator GRAMM said, you can buy the McDonald's franchises for that. I expect you could.

For people who say the cost impact of the Kennedy bill is trivial and it would do no damage, if they believe that, have them vote for this amendment. I hope they will vote for this amendment.

We should do no harm. We should not increase the cost of health care by more than 1 percent. Shame on us if we do. We should do no harm. We should not increase the number of uninsured. We should not be passing bills that make matters worse. Let's work on quality. Let's improve access. Let's make sure more people have health

care. Let's not do just the opposite. Let's not uninsure a couple million people by increasing the cost of health care so dramatically, as the Kennedy bill would do. That is the purpose of our amendment.

I compliment my colleague from Texas, who has been working on this amendment as the principal cosponsor with me, and also my colleague from Maine who spoke so eloquently on it earlier.

I yield the floor.

The PRESIDING OFFICER. Who yields time?

Mr. REID. Mr. President, I yield, on the amendment, 5 minutes to the Senator from Florida.

The PRESIDING OFFICER. The Senator from Florida.

Mr. GRAHAM. Mr. President, virtually every provision in both versions of the Patients' Bill of Rights starts with a phrase similar to this: If a group health plan or health insurance coverage offered by a health insurer provides any benefits with respect to specialist care, emergency service care, primary care, then this is what they have to do. What does that say?

One, it says no health plan is required to offer virtually any of the services that are covered by this bill. It is all a matter of free contract between the HMO and those persons to whom an HMO contract is being sold. The analogy is, what is it that you buy when you sign an HMO contract that says you are going to get access to specialists.

To stay with the McDonald's example, the question is not what the hamburger costs. The question is whether there is any beef inside the hamburger or whether all you are paying for with your \$2 is a couple of buns.

The fact is, if there is an increase in cost, it probably means people aren't getting the kind of services they think they are getting when they contract with an HMO. We found out, as it relates to Medicare, that 40 percent of the complaints by Medicare beneficiaries against their HMO were in the emergency room. They went to the emergency room, they got treatment, and then they were found not to have a heart attack, not to have the onset of a stroke. That was the good news. The bad news was the HMO said: Well, because you went to the emergency room and you didn't have a heart attack, we are not going to pay your bill.

Is that the way we want to hold down the cost of care, by having essentially a bait-and-switch process built into one of the most intimate aspects of an American family's relationships, and that is how their health care will be provided and paid for?

The issue is whether people are going to get what they contracted for. If they don't want to contract for these services and therefore have a lower cost product, they are at liberty to do so.

The irony is, to go back to the last discussion we were having on the emergency room, the very provision that

apparently is going to be substantially altered, in the unseen, unread, unknown Republican amendment that is being offered as an alternative to my emergency room amendment, has to do with poststabilization care. According to the oldest and one of the largest HMOs in the country, Kaiser-Permanente, which has voluntarily adopted exactly the procedure we are suggesting should be the standard for emergency room contract provisions, their use of poststabilization has saved them money. How has that happened?

Take the case of a child who has a high fever. The parents take the child to the emergency room. It is determined the child does not have a life-threatening condition, but there is uncertainty as to why they have had this high fever.

Under the Kaiser plan, the emergency room calls the HMO and says: Here is what the situation is with this child. What do you think would be the appropriate medical treatment? The HMO, Kaiser, and the emergency room work out a coordinated plan of treatment. In many cases, what it says is the child can go back home if the child, at 9 o'clock in the morning, will come to Kaiser's primary care physician to be treated. That is why Kaiser says it is not only good health but also it saves money.

Ironically, the first amendment offered, after it is stated by the opposition that they are going to strip, dilute, adulterate this provision which has the potential of saving money, is to offer this saccharin amendment which says: Now we will put a limitation on increases in cost.

I think we are all concerned about cost. We are all concerned about making health care more affordable and reducing the number of uninsured. But we want people who contract with an HMO to get what they paid for, not to get the two buns but no beef in their McDonald's hamburger.

Mr. GRAMM addressed the Chair.

The PRESIDING OFFICER. The Senator from Texas.

Mr. GRAMM. Mr. President, I yield myself 15 minutes.

I have to say we often see people do 180 degree turns around here. It never ceases to amaze me to hear our Democrat colleagues savaging HMOs. Let us remember they are the people who have been in love with HMOs for 25 years.

In fact, they loved HMOs so much that in these bills virtually crushing this ancient desk—the 1994 Clinton health care bill and the two Kennedy variations of it—they loved HMOs so much they would have set up health care collectives all over the Nation, run by the Federal Government, and would have fined Americans \$5,000 for refusing to join their health care collective. They loved HMOs so much in 1994, they would have imposed a \$50,000 fine on a doctor who prescribed medical treatment that was not dictated or allowed by their Government-run HMO health care collective.

They loved HMOs so much in 1994, if a doctor provided treatment you needed for your baby that was not provided for in their Government-run health care collective, and you paid him for it, he could go to prison for 15 years. That was their vision of a health care future for America.

But having loved HMOs so much that they wanted to mandate that everybody in America be a member of one run by the Government, now all of a sudden they have done a public opinion survey. They have gotten focus groups together, and they have decided Americans are not as much in love with HMOs as they are. And so as a result, now they have a bill that doesn't say, as they said in 1994, HMOs are the answer to everything. They have a bill that now says HMOs are the problem.

What we try to do in our bill is fix the problems, but we do something they will not do: We empower Americans to fire their HMO. We allow Americans to buy medical savings accounts, where they have the right to choose for themselves.

Our Democrat colleagues are adamantly opposed to that freedom because they want the Government to run the health care system. And you can't get the Government running the health care system if you start giving people the power to fire their HMO. So they want to regulate the HMOs. They want to give you the ability to contact a bureaucrat if you are unhappy. They want to give you total freedom to hire a lawyer. You can hire whatever lawyer you want to hire.

But what they will not do is give you the ability to hire your doctor. Why don't they want to do it? Because this is simply one step in the direction of this health care bill that they want and love, and which we killed. But in their heart, they still want Government health care collectives, and they want people fined and imprisoned if they don't provide medicine exactly the way the Democrats want it provided.

Now they say, well, something is wrong with the Republican bill because they are not overriding State law. They think that somehow Senator KENNEDY and President Clinton know more about Texas than the people in the Texas Legislature and the Texas Governor. They believe we should trample State law and we ought to make every decision in Washington, DC. We don't agree. They say they want America to know the difference. Please know that this is the difference.

If Senator KENNEDY and President Clinton know so much about Texas, when President Clinton finishes in the White House, maybe he ought to move to Texas and run for some public office. It would be an educational experience, I can assure you, both for him and the people of Texas.

But the point is, I am not going to let Senator KENNEDY and President Clinton tell the people in Texas how to run

their State. I am not going to do it either. If I wanted to do that, I would run for the state legislature.

Let's get to the issue we are talking about here. The problem with the Kennedy bill is it drives up costs. The problem with the Kennedy bill is that the Congressional Budget Office has concluded that the Kennedy bill would drive up health care costs by 6.1 percent.

What that means is two things: One, 1.8 million Americans would lose their health insurance. Now, granted, if their bill passed, you would have the ability to pick up the phone book, look in the blue pages and call any government agency you wanted; you could hire any lawyer you wanted. But 1.8 million people would not have health insurance under this bill. Their bill would drive up health costs for those who got to keep their insurance by \$72.7 billion over a 5-year period.

Let me convert that into something people understand. By 1.8 million people being denied health insurance because of the cost of all these lawyers and Government bureaucrats and therefore losing their insurance under the Kennedy bill, that would mean that in breast exams, 188,595 American women would lose breast exams that they would have under current law because Senator Kennedy's bill would drive up health insurance costs so much.

Because 1.8 million people would lose their health insurance under the Kennedy bill, there would be 52,973 fewer mammograms. Why? Is Senator Kennedy against mammograms? Of course he is not. But the point is, his bill, by driving up costs, by hiring all these bureaucrats and all these lawyers, where 60 percent of what comes out of these lawsuits goes to lawyers and not to people who have been damaged, hurt, or are sick—by imposing those new costs, 52,973 women per year would lose mammograms that they are getting, which are funded today under their health insurance policies.

Under Senator KENNEDY's bill, 135,122 women that get annual pap tests funded by their insurance policy would not get them because they would lose their insurance.

And so that no one thinks I am totally discriminating against men, prostate screenings would decline by 23,135. That's 23,135 men who would not get screened, who might die of prostate cancer because Senator KENNEDY thinks it is more important to be able to hire a lawyer than it is for people to have insurance so that they can get prostate screening.

Really, the bill before us is not about doctors. Nothing in Senator KENNEDY's bill lets you choose your doctor or fire your HMO. It lets you choose a lawyer and contact a bureaucrat. In doing so, it drives up costs by 6.1 percent and it denies 1.8 million people their health insurance. As a result, we get less care, not more; we get more expensive care, not cheaper. And anybody that believes

that being able to hire a lawyer or contact a bureaucrat heals people clearly does not understand how medicine works.

The amendment before us is a very simple amendment. My guess is that after they pray over it a while, everybody will vote for it. It kills the Kennedy bill, no question about that. But I don't think they are going to want to vote against it because what this amendment says very simply is this: It sets up a triggering mechanism. It says that if this bill were to be adopted—which it won't be because we are going to defeat it this week because we have a better bill that works better—if it was found and certified that in any year, when fully implemented, this bill would drive up costs by more than 1 percent, the law would not go into effect. Or if in any year more than 100,000 people lost their health insurance as a result of the cost increase also imposed, then this bill would not be operative.

Now we know from CBO estimates that both of these things will occur. We have offered this amendment basically to point out the fact that the problem with the Kennedy bill is that it drives up costs, and it denies people health insurance.

Finally, let me say do I believe this is the end game? Suppose for a moment that we could pass their bill, if President Clinton could override every legislature and State, and we could have the Government decide, by law, what is the preferred service, what is the means of treating every disease so we would set by Federal statute all those things. Suppose that we did all those things and drove up health care costs, would the Democrats be happy? No, and neither would the American people.

Next year, they would come back with their old faithful, the Clinton health care bill, and they would say: Medical costs have risen by 6.1 percent, 1.8 million people have lost their health insurance, and there is only one solution. We have to have the Government take over the health care system. We will make everybody join an HMO. We will take their freedom completely away, and, in fact, we will fine them \$5,000 if they refuse to do it, and we will make doctors practice medicine our way. We will fine them \$50,000 if they give a treatment we don't approve, or we will put them in prison if they provide medical care that is not on our approved Federal list. That will be their answer to the problem they create with this bill. That is what this debate is about.

I am sure, having looked at their bill, they have done a poll, they have looked at a focus group, and they have determined that somehow they are going to gain some political points by the bill they put forward.

We have gone about it a little bit differently. We have spent 2 years with people such as BILL FRIST—who has actually practiced medicine; not only

practiced, he is one of the premier doctors in America—putting together a bill that fixes the problems with HMOs, that doesn't write medical practice into law. If we had written medical practice into law 100 years ago, we would still be bleeding people for fevers.

We have put together a bill that tries to deal with abuses in HMOs so a final decision is made by an independent doctor as to what "necessity" is. We go a step further. We expand freedom so that people get a chance with our reforms, if they are not happy with their HMO, they can say something under our bill to the HMO that they can't say under Senator KENNEDY's bill. Under our bill, if all else fails, they can say to their HMO: You didn't do the job. You didn't take care of me, you didn't take care of my children, and you are fired. I'm going to get a medical savings account. I'm going to make my own decisions.

That is the difference between what Democrats call rights and what Republicans call freedom. Their rights are the right to more government, the right to more regulation, the right to look in the blue pages and call up a government bureaucrat, to look in the Yellow Pages under "Attorney" and call up a lawyer.

But their health care rights do not include the right to hire your own doctor or to fire your HMO. What kind of right is it when you have a right to complain and petition but you don't have a right to act?

Our bill is about freedom, the freedom to choose. That is the difference. Our Democrat colleagues don't support that freedom, because they want a government-run system.

Senator KENNEDY is not deterred. We may have killed the Clinton-Kennedy bill in 1994 taking over the health care system, but he dreams of bringing it back. If he can win on his bill this week, it is a step in that direction. But he is not going to be successful.

I yield the floor.

The PRESIDING OFFICER. Who yields time?

If no time is yielded, the time is shared equally.

Mr. NICKLES. Mr. President, I want to make a couple more comments. I think some people have been loose with facts on saying the Kennedy bill would only cost \$1 a month. One Member said it would only cost one Big Mac a month. That is absolutely, totally false.

I have been looking at the Congressional Budget Office cost estimate of the Kennedy bill, S. 6, the Patients' Bill of Rights of 1999. I will read a couple of provisions. If this report is wrong, I wish to be corrected. Members are making statements that it will only cost \$2 a month, or one hamburger a month—unless they are buying that hamburger in Cape Cod or Hyannis Port. Maybe that is \$30 a month. It is not a Big Mac in Oklahoma.

Page 3 of the CBO report says most of the provisions would reach the full effect within the first 3 years after enactment. CBO estimates the premiums for employer-sponsored health care plans would rise by an average of 6.1 percent in the absence of any compensating changes on the part of employers.

What would the compensating changes be? CBO says, on page 4, employers could drop health insurance entirely if we pass the Kennedy bill. Employers could drop health insurance entirely, which I am afraid many would do. They could reduce the generosity of the benefit package, according to CBO, increase the cost sharing by beneficiaries, or increase the employee's share of the premium.

This is CBO. This is not just DON NICKLES. This is not some right-wing conspiracy. They are saying if health care costs are increased this much, some employers will drop plans. Some employers will say employees have to pay a lot more. Some employers will come up with cheaper plans. CBO said some will reduce the generosity of the benefit package, come up with cheaper plans, not cover so much.

I thought the purpose of the bill was to improve health care quality, not come up with cheaper plans, not come up with fewer plans, not come up with greater uninsured. That is what CBO is saying increased costs would be.

How much would it cost? Again, I am a stickler for having facts. What is the estimated budgetary impact of the Kennedy bill? CBO says it would reduce Social Security payroll taxes by about \$8 billion over the next 10 years, reducing Social Security payroll taxes by \$8 billion. That means total payroll goes down by \$64 billion. That is a big reduction. That is a lot of money coming out. That is a lot of money that people won't receive in wages, according to the CBO, because Congress passed a bill. Congress said: We know better; we should micromanage health care from Washington, DC. The net result is lost wages of \$64 billion. That is not one Big Mac per month.

What is the cost per month? Family premium for health insurance, according to Peat Marwick: \$5,826 in 1998; 6.1 percent of that is \$355 per year. That is right at \$30 per month an employer would pay. What does CBO say the employer would do if they were saddled with those kinds of increases? They would drop plans, drop health insurance entirely, reduce the generosity of the benefit package, increase cost sharing by beneficiaries, or increase the employees' share of the premium.

We should use facts. The cost of the Kennedy bill is not one Big Mac; it is about \$30 a month for a family plan. According to CBO, I am afraid a couple of million people, at least 1.8 million people, would lose the insurance they already have. We should not do that. That would be a serious mistake.

Mr. FRIST. Will the Senator yield?

Mr. NICKLES. I am happy to yield.

Mr. FRIST. It is important for us to look at the CBO reports because they have obviously looked at various mandates in this bill. I ask the Senator if this is correct. It says:

CBO finds the bill as introduced [Senator KENNEDY's bill] would increase the cost of health insurance premiums by 6.1 percent.

Is that correct?

Mr. NICKLES. That is correct.

Mr. FRIST. Does that 6.1-percent increase include the cost of inflation in health care? Or is that separate from that?

Mr. NICKLES. The Senator makes an excellent point. That is over and above whatever inflation is already anticipated for health care costs.

Mr. FRIST. So we have health care inflation. We know we worked hard to reduce it, but the rate of health care inflation already is two or three times that of general inflation. So that is already built into the equation. The increase, because of the Kennedy bill, is an additional 6.1 percent; is that correct?

Mr. NICKLES. That is correct.

Mr. FRIST. So we are talking about a potential increase of 9, 10, 11 percent in premiums?

Mr. NICKLES. Even higher than that. I think the estimate I have, that was done by the National Survey of the Employee-Sponsored Health Care Plans, Mercer, which is probably one of the biggest actuaries in health care, estimates a 9-percent increase for next year in health care costs. So if you put 6.1 percent on top of that, that is a 15-percent increase in health care costs for next year.

Mr. FRIST. So we have health care going to 10, 11, 12, 13, 14, 15 percent, possibly higher because of the bill, coupled with things we cannot control. Yet we know this bill is something we can control.

For every 1 percent increase in premiums—you say it is going to be 10, 12, 13, 14, 15—how many people are driven to the ranks of the uninsured?

Mr. NICKLES. Most of the professionals and actuaries usually estimate about 300,000.

Mr. FRIST. The reasons for that seem to me to be fairly obvious. With premiums going sky high, and you are a small employer and trying to do the very best to take care of your employees and offer them insurance and you are barely scraping by with your margins, as small businesspeople are working so hard to do, is it not correct that an 11-, 12-, 15-percent increase is enough to make you say I just cannot do it anymore?

Mr. NICKLES. Unfortunately, that is the case.

Mr. FRIST. Is it correct, what the CBO says, responding to, "How will employers deal with these costs?" Do you agree with what the CBO says:

Employers could respond to premium increases in a variety of ways. They could drop health insurance entirely, reduce the generosity of the benefit package . . .

I tell you, as a physician, neither of those sound very attractive to me. We

have to be very careful in this body that we don't cause them to drop their insurance or decrease their benefits package. I continue back with the quote:

. . . increase cost sharing by beneficiaries . . .

As an aside, I am not sure we want to throw that increased cost sharing on our beneficiaries unless it is absolutely necessary.

. . . increase the employees' share of the premium. CBO assumed employers would deflect about 60 percent of the increase in premiums through these strategies.

Mr. President, 60 percent, that is almost unconscionable unless these mandates are entirely necessary.

Mr. NICKLES. I thank my friend and colleague. He makes an excellent point. Again, this is CBO saying if we do this, employers are going to drop health insurance or they are going to drop the quality of the package. He makes an excellent point.

Mr. President, I yield the floor.

The PRESIDING OFFICER. Who yields time?

Mr. FRIST. Mr. President, I yield myself 5 minutes.

The PRESIDING OFFICER. The Senator from Tennessee.

Mr. FRIST. Parliamentary inquiry. How much time remains?

The PRESIDING OFFICER. The Senator has 6 minutes 10 seconds.

Mr. FRIST. And on the other side?

The PRESIDING OFFICER. On the other side, 5 minutes 51 seconds.

Mr. FRIST. Mr. President, this Patients' Bill of Rights is critical. For us to come in and return the balance between physicians and patients in managed care—and I think managed care has gone too far—we need to absolutely make sure patients and physicians are empowered so the very best care is given to that patient. It means we in this body have to be very careful not to drive the cost just sky high, through the roof. Why? Because all the information, all the data presented to us is if we make these premiums skyrocket people are going to lose their insurance.

We have not talked about that very much. I mentioned it to my colleagues. Is very important to get some insurance coverage. Some coverage gets you into the door. That makes sure you have access to health care.

If we look at the President's own advisory commission on managed care, they were very careful to consider costs. I think we should be, just as they were, very careful.

This is one of their guiding principles of President Clinton's Advisory Commission on Consumer Protection and Quality in the Health Care Industry. They basically say:

Costs matter . . . the commission has sought to balance the need for stronger consumer rights . . .

As an aside, we have to do that and accomplish that in this bill we have before us this week.

. . . with the need to keep coverage affordable . . . Health coverage is the best consumer protection.

I agree with this. We need to come back to this guiding principle and consider cost.

We talk about the mandates. Let me say, because I mentioned the commission, we have a lot of mandates in the underlying Kennedy bill. I think we need to go through and see what other people have said about these mandates; are they necessary? Because we know unlimited mandates imposed on insurance companies, States, individuals, if they are not necessary, are going to drive costs up and decrease access. If we look at the Democratic mandates—and I just put a few on here to see whether or not President Clinton's Advisory Commission on Consumer Protection and Quality recommended them—you will find the following.

Under a medical necessities definition, something we will be debating over the next couple of days: Rejected under the President's commission.

Under the health plan liability, coming back to bringing the lawyers into the emergency room and suing everyone: Rejected; mandatory repeal of standardized data, rejected by President Clinton's commission; State-run ombudsman program, rejected by the President's commission; restriction on provider financial incentives, rejected by the President's commission. All of these are mandates in the Kennedy bill today, all of which were rejected by the President's own commission.

Rules for utilization review, section 115 in S. 6, the Kennedy bill: Rejected by the commission. Provider non-discrimination based on licensure, rejected by the commission.

The point is not so much each of these and the sections I have enumerated here, 151, 302, 112, 151. The point is, in this body, as we go forward, we have to be very careful in all of the rhetoric and all of our commitment and all of our hard work, legitimately, on both sides, to protect patients. We have to be very careful not to go too far out of good intentions, to the point that it is unnecessary, if they do not need those rights, and it also drives the cost up.

So when you go through the Kennedy bill and see these mandates, President Clinton's own Advisory Commission on Consumer Protection and Quality looked at them, considered them, but rejected them.

Why? I cannot tell you for sure why because I was not in the room, but I think it comes back to the amendment we are talking about today and to what they have actually said in their guiding principles: Costs do matter.

The commission has sought to balance the need for stronger consumer rights—

Just as we are in our Republican Patients' Bill of Rights Plus bill—

with the need to keep coverage affordable. . . . Health coverage is the best consumer protection.

I look back at Tennessee. Looking at the uninsured and the costs associated with the underlying Kennedy bill, the number in Tennessee that we throw to the ranks of the uninsured would be

20,872. Again, we talked about the 1.8 million nationwide. Look to our own individual States.

The PRESIDING OFFICER. The time of the Senator has expired.

Mr. FRIST. Mr. President, I will close simply by saying I am very glad this amendment was brought to the floor because very early on it says this debate is more, it is in addition to just patient protections. Why? Because the ultimate patient protection means you get good quality of care and you have access to that care. So over the next several days our primary objective is to increase that quality of care, strong patient protections, but do all that without hurting people, without throwing them to the ranks of the uninsured.

That is our challenge. That is why I am very proud of our underlying Republican bill and look forward to supporting it and gathering more support as we go over the next several days.

I yield the floor.

The PRESIDING OFFICER. Who yields time?

If neither side yields time, time will be charged equally.

Mr. KENNEDY addressed the Chair.

The PRESIDING OFFICER. The Chair recognizes the Senator from Massachusetts.

Mr. KENNEDY. Mr. President, what is the time situation?

The PRESIDING OFFICER. The side of the Senator from Massachusetts has 35 minutes; the other side has used up all its time.

Mr. KENNEDY. It is our intention to respond to these arguments briefly and then offer an amendment. I yield myself 5 minutes.

Mr. President, as we see in this institution, there are amendments which are offered that are poison pill amendments. They are amendments that effectively kill legislation. That is really the purpose of this; we ought to be very clear about it. Senator GRAMM of Texas has indicated if that amendment is accepted, this whole debate comes to a halt and it ends any possibility of a Patients' Bill of Rights. That is what we are faced with at this time.

We will have an opportunity to judge whether the Senate wants to end any consideration of a Patients' Bill of Rights—or whether this is an issue that ought to be considered—when we vote on that particular amendment. We will have a chance to vote on the various amendments we have outlined and presented in different forms. We will continue to discuss these amendments over the course of this debate.

One of the techniques used in this institution—perhaps less so now than in the past—is to present the opposition's arguments with distortion and misrepresentation, and then differ with the distortions and misrepresentations. We saw a classic example of that with my good friend, the Senator from Texas, Mr. GRAMM. He went through this whole routine about what was in this bill and then he, in his wonderful way, differed with it, like only he had

common sense and understanding of what is in that legislation.

Before responding to that, I start out with the basic core issues, which have been raised again and again by those who are opposed to our bill: One, costs; and, two, coverage.

When all is said and done and after we have listened to the distortions and misrepresentations of our good Republican friends, here is, majority leader TRENT LOTT on NBC "Meet the Press" saying: By the way, the Democrat's bill would add a 4.8 percent cost.

This is the Republican majority leader agreeing with the Congressional Budget Office figures. Maybe the other side gets a great deal of satisfaction—they certainly take a lot of time to distort and misrepresent the facts. But let's look at 4.8 percent—or even 5 percent—impact on a family's premium over 5 years. The family's premium might be \$5,000 a year. Looking cumulatively at 5 percent—1 percent a year—that would be \$250 for the total of 5 years, \$50 a year.

You can misrepresent the figures, you can distort the figures, you can frighten the American people, which is a common technique; it was done on family and medical leave. Do you remember that argument put out by the Chamber of Commerce about the cost of family and medical leave to American business? They still cannot document it. Do you remember, when we had the minimum wage debate, claims about the cost to American business? They still cannot document it. As a matter of fact, Business Week even supports an increase in the minimum wage.

Now on the third issue, here it comes again, the bought-and-paid-for studies by the insurance industry. That is what these studies are all about. They are bought and paid for by the insurance companies, and they distort and misrepresent.

Mr. NICKLES. Will the Senator yield?

Mr. KENNEDY. I will not yield at this time. You would not yield last evening when I was trying to ask Republicans about particular provisions.

How many times did we hear from the other side: Let's rely on the Congressional Budget Office, they know what is best. We were just with the President of the United States. He said every time he sat down with the Republican leadership, they said: We will not do anything unless we get the CBO figures.

We have given you the CBO figure. The majority leader agrees with the CBO figure. Let's put that aside.

The second issue is coverage. The issue is whether more people will lose their health insurance coverage because we are going to do all of the things that Senator GRAMM talked about. I yield to no one on the passage of health care in order to expand coverage. The idea that the groups in support of this particular proposal would support a proposal which means that 2

million Americans would lose coverage is preposterous on its face. On the one hand, they are so busy over here saying: Look who is supporting your program, the AFL-CIO. Do you think they are going to support legislation—I yield myself 2 more minutes—that will cause 2 million Americans to lose coverage? Are we supposed to actually believe that? Or all the many groups—I will not take the time to enumerate them—that support a comprehensive program to expand coverage? That is poppycock. That is baloney. They even understand that in Texas. It is baloney.

The idea that 180,000 women are going to lose breast cancer screening, 52,000 a year are going to lose mammograms, 135,000 women in this country are going to lose Pap tests when the American Cancer Society supports us lock, stock, and barrel—come on, let's get real. Whom do you think you are talking to, the insurance companies again? Can you imagine a preposterous statement and comment like that coming from the Senator from Texas? That just goes beyond belief.

I will make a final comment or two about freedom. We heard a lot about freedom. Remember that, we heard all yesterday afternoon about freedom? We heard about freedom this morning. We heard about freedom: We are for freedom. The other side is not for freedom, but we are for freedom. Support our position, you will be for freedom.

The insurance companies want freedom from accountability. That is what they want, freedom to undermine good quality health care for children, for women who have cancer, for the disabled. That is what they want—freedom from accountability and responsibility.

That is baloney, too. We want accountability. I am surprised to hear from the other side all the time about how they want personal responsibility and accountability.

I ask for another 2 minutes.

They always want personal responsibility and accountability with the exception of HMOs. Sue your doctors, fine, but not your HMOs, not your insurance companies, not those that have paid \$100 million and effectively bought this Republican bill—yes; that is right—those provisions are dictated by the insurance companies.

That is what we have. The American people are too smart to buy that.

I know there are others who want to speak. I yield back my time.

AMENDMENT NO. 1237 TO AMENDMENT NO. 1236

(Purpose: To provide coverage for certain items and services related to the treatment of breast cancer and to provide access to appropriate obstetrical and gynecological care, and to accelerate the deductibility of health insurance for the self-employed)

Mr. KENNEDY. I send an amendment to the desk and ask for its immediate consideration.

The PRESIDING OFFICER. The clerk will report the amendment.

The legislative assistant read as follows:

The Senator from Massachusetts [Mr. KENNEDY], for Mr. ROBB, for himself, Mrs. MURRAY, Mrs. BOXER, Ms. MIKULSKI, Mr. KENNEDY, Mr. REID, Mr. DURBIN, Mr. FEINGOLD, Mrs. LINCOLN, Mr. DASCHLE and Mr. BYRD proposes an amendment numbered 1237 to amendment No. 1236.

Mr. REID addressed the Chair.

The PRESIDING OFFICER. The Senator from Nevada.

Mr. REID. Parliamentary inquiry. That amendment is offered on behalf of Senator ROBB and others; is that so?

The PRESIDING OFFICER. Yes.

Mr. REID. I ask unanimous consent reading of the amendment be dispensed with.

The PRESIDING OFFICER. Is there objection?

Without objection, it is so ordered.

(The text of the amendment is printed in today's RECORD under "Amendments Submitted.")

The PRESIDING OFFICER. Who yields time?

Several Senators addressed the Chair.

The PRESIDING OFFICER. The Senator from Oklahoma.

Mr. NICKLES. I would like to make a few comments. I will not address the amendment that was just sent to the desk, but I would like to respond to my colleague.

First, I started to call Senator FRIST. Sometimes I call him because we need help on the floor to debate things, such as medical necessity or other medical procedures. This time I thought I would call him because I thought we might need him because I was afraid somebody might have a heart attack getting so excited in the debate.

But let me just touch on a couple of comments that my good friend and colleague, Senator KENNEDY, made. He said: Enough about this cost stuff. He said: That was done by some study that was bought and paid for by the insurance companies.

Correct me if I am wrong, but I stand corrected if the Congressional Budget Office is bought and paid for by the insurance companies. If so, I would like to know it. I am not aware of that.

My colleague alluded to the fact that Republicans are bought and paid for. He was close to getting a rule invoked. I do not think he meant to say that. I will let that go.

I am not going to make allusions that trial lawyers have bought one side or that the unions have bought one side, although he did mention that the unions support his bill. It just happens to be that the unions are exempt from his bill. That is interesting. They are exempt for the duration of their contracts.

So his bill basically tells every private employer: You have to rewrite your contract next year, except for unions. Oh, if you have unions, you don't have to redo it until the end of your contract. If the contract is for 4 years, you don't have to touch it for 4 years. But anybody else, you rewrite it next year.

Maybe that is the reason the unions have signed on. Maybe there are other

reasons or other special interest groups that have gotten into his bill.

But back to the cost. My colleague says: Well, it is only 1 percent per year. CBO says the cost would be 6 percent when it is fully implemented in 3 years—not 5 years. So Senator KENNEDY is able to say: Well, we think it is about 5 percent over 5 years; therefore, it is a 1-percent per year cost increase. And employees only pay 20 percent, which is how he gets his one Big Mac per month. It just does not work. It does not equate. The bill, when fully implemented, is 6.1 percent. That is in 3 years, and the cost is \$355 per year.

If that happens, you are going to have a lot of people, according to CBO—not some study financed by the insurance companies—who are going to lose their coverage, a lot of people who are going to get less quality coverage, people who are going to have to pay a greater percentage of the coverage, people who are going to have to pay a greater percentage of the premiums if we pass the Kennedy bill. That is the bad news. The good news is we are not going to pass it.

But I think we have to stay with the facts. The facts are that the Kennedy bill increases costs dramatically and increases the number of uninsured dramatically. That would be a serious mistake. That is something we are not going to allow to happen.

Mr. President, I yield the floor.

The PRESIDING OFFICER. Who yields time?

Mr. KENNEDY. Mr. President, I yield 10 minutes to the Senator from Virginia.

The PRESIDING OFFICER. The Senator from Virginia.

Mr. WELLSTONE. Before the Senator speaks, may I do two quick things?

PRIVILEGE OF THE FLOOR

Mr. President, I ask unanimous consent that Renato Mariotti, an intern, be allowed on the floor during this debate today.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. WELLSTONE. I ask unanimous consent that I follow Senator ROBB after we get back from caucuses, that I be first in order.

The PRESIDING OFFICER. Is there objection?

Without objection, it is so ordered.

Mr. ROBB addressed the Chair.

The PRESIDING OFFICER. The Senator from Virginia has 10 minutes.

Mr. ROBB. Thank you, Mr. President. And I thank my colleague from Massachusetts.

Mr. President, while I would concede that most Members of this body are very concerned about issues that have special relevance to women, we all too often leave much of the advocacy on those issues to women who are colleagues in the Senate. In a legislative body with only 9 women and 91 men, the amount of time focused on issues of special concern to women is often skewed. As someone who has always

prided himself on standing up for equality of opportunity, that seems profoundly unfair.

Women's health—and, specifically, the choices women have in our health care system—ought to be a special concern to everyone.

As a father of three daughters, I have come to better understand that the types of health care women need and the way they access it are often very different from the health care needs of men.

Unfortunately, our health care system has long ignored some important facts about women's health. During this important debate on the Patients' Bill of Rights, I have offered an amendment that would do something to correct that. I rise to explain the amendment which was just sent to the desk which will help women get the medical care they need.

The amendment has been crafted with Senators MURRAY, BOXER, and MIKULSKI and will remove two of the greatest obstacles to quality care that women face in our current system today: No. 1, inadequate access to obstetricians and gynecologists; and, No. 2, inadequate hospital care after a mastectomy.

We know today that for many women, their OB/GYN is the only physician they regularly see. While they have a special focus on women's reproductive health, obstetricians and gynecologists provide a full range of preventive health services to women, and many women consider their OB/GYN to be their primary care physician.

Unfortunately, some insurers have failed to recognize the ways in which women access health care services. Some managed care companies require a woman to first visit a primary care doctor before she is granted permission to see an obstetrician or gynecologist. Others will allow a woman to obtain some primary care services from her OB/GYN but then prohibit her from visiting any specialists to whom her OB/GYN refers her without first visiting a standard primary care physician. This isn't just cumbersome to women; it is bad for their health.

According to a survey by the Commonwealth Fund, women who regularly see an OB/GYN are more likely to have had a complete physical exam and other preventative services—like mammograms, cholesterol tests, and Pap smears.

At a time when we need to focus our health care dollars more toward prevention, allowing insurers to restrict access to health professionals most likely to offer women preventative care only increases the possibility that greater complications and greater expenditures arise down the road.

We ought to grant women the right to access medical care from obstetricians and gynecologists without any interference from remote insurance company representatives. This amendment is designed to do just that.

I offer this amendment on behalf of my colleagues because the Republican

bill, which has been offered for the purposes of debate by Senator DASCHLE, will not grant women direct access to care.

First of all, their bill only covers a limited percentage of the women who have health care insurance in our country, leaving more than 113 million Americans without any basic floor for patient protections. Then, for the minority of patients that they do cover, the Republicans offer only a hollow set of protections but leave many women without direct access to the care they need. While their bill would allow a woman to obtain routine care from an OB/GYN, such as an annual checkup, the bill would not ensure that a woman can directly access important followup obstetrical or gynecological care after her initial visit. For example, if a woman were to have a Pap smear during a routine checkup at her gynecologist, and that Pap smear came back abnormal, the Republican bill would not guarantee that she could access important followup care from the same doctor.

Instead, their bill would allow insurers to force her to go back to a primary care gatekeeper physician to get permission for a followup visit to her gynecologist. This may sound unbelievable, but a recent survey showed that women face this obstacle 75 percent of the time. In addition, the Republican bill will now allow a woman to designate her OB/GYN as her primary care provider.

Their provision ignores one of the basic facts about the ways women receive health care in America today. While OB/GYNs have a special expertise on women's reproductive systems, they are also trained at primary care. For women, their OB/GYN is the only doctor that they see on a regular basis.

Because many of these women consider their OB/GYN to be their primary care physician, they depend on him or her for the full range of diagnostic and preventative services that are offered by other general practitioners. Statistics show that women are more likely to have had a physical from an OB/GYN in the past year than from any other doctor. One survey from the University of Maryland showed that OB/GYNs provide 57 percent of the general physical exams given to women. In another survey, when asked who they go to for primary care, 54 percent of the women said it is to their OB/GYN.

We know how women access primary care and we know that by allowing them to get this care, their health care will improve. Yet insurers often ignore the fact that many women rely on their OB/GYN for primary care, making it more difficult for them to access preventative care and other services.

Our amendment will grant women more direct access to health care professionals that they have come to depend upon.

The second piece of this amendment will address the inhumane treatment that some women have received after

they have experienced the trauma of a mastectomy. Each year, millions of women are screened for cancer by mammogram and, sadly, nearly 200,000 of them are diagnosed with breast cancer.

The options women face in such circumstances are difficult, and in a time of great uncertainty, women ought not be forced to face unnecessary additional burdens. Unfortunately, some women have been told by their health insurer that a mastectomy will only be covered on an outpatient basis. Given the trauma that a woman faces with such major surgery, both physical and emotional, it is unconscionable that some insurers refuse to cover proper hospital care after a mastectomy. Much like the restrictions on access to obstetricians and gynecologists, these restrictions on hospital care after such traumatic surgery are simply bad for women's health. After a mastectomy, doctors tell us that hospitalization is often critical to foster proper healing, as well as to provide support to women who have just experienced the emotional trauma of such major surgery.

Our amendment will return control over this important medical decision to the medical professionals and ensure that doctors who actually know and examine their patients, not some distant, impersonal insurance company representative, make decisions about the length of stay in the hospital following a mastectomy. It would put into law the recommendations of the American Association of Health Plans, who said in 1996, that:

The decision about whether outpatient or inpatient care best meets the needs of a woman undergoing removal of a breast should be made by the woman's physician after consultation with the patient . . . as a matter of practice, physicians should make all medical treatment decisions based on the best available scientific information and the unique characteristics of each patient.

Although this commonsense, important provision was included in legislation offered by the other side of the aisle last year, it has inexplicably been dropped from their bill this year. We cannot, however, retreat from our commitment to the health and well-being of the women of America.

Finally, this amendment would help self-employed women and, indeed, all self-employed Americans better access affordable health insurance by making the cost of their insurance fully tax deductible.

The PRESIDING OFFICER. The Senator's 10 minutes has expired.

Mr. ROBB. I ask for 1 additional minute.

Mr. KENNEDY. Fine. Are we still recessing at 12:30?

The PRESIDING OFFICER. Yes. That is the order.

Mr. ROBB. Finally, this amendment would help self-employed women and, indeed, all self-employed Americans better access affordable health care by making the cost of their insurance fully tax deductible. The current tax

system penalizes self-employed individuals, and this amendment will ensure they are treated equally.

I am concerned that the bill offered by the other side doesn't even cover 70 percent of Americans with health insurance. I am even more concerned, however, that the protections they offered to this limited number of Americans doesn't reflect the health needs of half of our population, the women in our population.

I know we can do better. We should do better. I urge my colleagues to support this amendment which recognizes the critical needs facing the women in this country today.

With that, I yield the floor, and I reserve any time remaining on my side.

The PRESIDING OFFICER. Under the previous unanimous consent, the Senator from Minnesota—

Mr. KENNEDY. Mr. President, I ask unanimous consent that that consent agreement be vacated.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. KENNEDY. I yield 2½ minutes to the Senator from Washington and 2½ minutes to the Senator from Maryland.

The PRESIDING OFFICER. The Senator from Washington.

Mrs. MURRAY. Mr. President, I rise as a sponsor of this amendment to protect women's health. This amendment offers true security to women; it deals with women's access to health care and women's treatment when they receive that care. This amendment ensures women get more than just routine care when they visit their obstetrician/gynecologist and it protects women against the pain and danger of so-called drive-through mastectomies.

While the underlying Republican bill does allow access to OB/GYN care, the HELP Committee went to great lengths to ensure women only had access for routine care—and nothing more. Let me quote from the committee report, "The purpose of this section is to provide women with access to routine OB/GYN care by removing any barriers that could deter women from seeking this type of preventive care." While the Republicans recognize the need for direct access, the language of their bill and their report makes it clear that direct access is guaranteed only for routine care.

Let me explain what that means. If during a routine examination, a woman's OB/GYN finds a lump or an inconsistency in her breast, the OB/GYN would not be allowed to refer the patient for further examination. Instead, the woman would have to go back to the gate keeper and hope that her primary care physician approved the referral. We should all agree this is a waste of time and energy—time and energy that would be better spent dealing with the potential breast cancer.

A recent study conducted by the American College of Obstetricians and Gynecologists shows that managed care plans are keeping women from receiving the health care they need and

seeing the providers they choose. Sixty percent of all women who need gynecological care and 28 percent of all women who need obstetric care are either limited or barred from seeing their OB/GYNs without first getting permission from another physician. Once the patient is able to gain access to her own OB/GYN, she is forced to return to her primary care gate keeper for permission to allow her OB/GYN to provide necessary follow-up care almost 75 percent of the time.

What my Republican colleagues fail to understand is that women need OB/GYN care for much more than simple routine care. They also fail to understand the important relationship between a woman and her own OB/GYN. OB/GYN providers are often a women's only point of entry into the health care system.

Our amendment would allow women direct access to OB/GYN care and follow-up care as well. It would also allow a woman to designate an OB/GYN provider as her primary care physician. We know historically that women have not been treated equally in receiving health care. We know that some physicians do not treat women with the same aggressive strategies as they treat their male patients, especially when women complain about depression or stress.

What we do know is that OB/GYNs have traditionally been strong advocates for women's health. They understand the physical and emotional changes a woman experiences throughout her life. The 1993 Commonwealth Fund Survey of Women's Health found the number of preventive services received by women, including a complete physical exam, blood pressure test, cholesterol test, breast exam, mammogram, pelvic exam, and pap smear, are higher for those whose regular physician is an OB/GYN than for those whose primary care doctor is not. Women are simply afforded greater access to preventive and aggressive health care services with OB/GYNs.

I am not sure why some of my Republican colleagues want to deny unobstructed access to important health care services for women. It cannot be about costs. The Congressional Budget Office estimated that the cost of direct access and primary care by OB/GYNs as only 0.1 percent of premiums. If my colleagues are so concerned about costs, can't they at least guarantee that women get the quality health care they pay for? This amendment ensures they will.

The other important provision in this amendment prohibits drive through mastectomies. It is outrageous that current trends in health care could force women to endure a mastectomy on an outpatient basis. It is wrong to send these women home to deal with the emotional and physical pain of the operation—as well as with the responsibility for draining surgical wounds and performing other post-surgical care. These women should not be abandoned during their time of need.

However, our amendment does not require a woman to stay in the hospital. Our amendment does not require a hospital stay for a set number of hours. Our amendment does require that the physician, in consultation with the patient, decides how long the woman should remain in the hospital. The physician determines what is medically necessary and what is in the patient's best interest.

I cannot believe there is anyone in this chamber who would want to see a loved one go through a mastectomy and be forced by her insurance company to go home immediately. If we have any compassion at all we should adopt this provision.

Let me respond to one criticism I've heard about this amendment from insurance companies. Some have claimed they do not have a policy of drive through mastectomies. I commend them and hope they would support this amendment to prohibit this cruel practice by other companies. I would also add that while most insurance companies may not engage in this kind of outrageous behavior today, how can we insure they will not tomorrow?

Our amendment is about protecting and improving women's health. For that reason, the College of Obstetricians and Gynecologists support it. If my colleagues truly consider themselves champions of women's health, they must vote for this amendment. I can assure you that women will not be fooled by the empty promises in the Republican bill. We know the difference between routine and comprehensive OB/GYN care. We know how traumatic and life-altering a mastectomy can be. We know we need real protection and this amendment provides it.

Mr. President, I especially thank Senator ROBB for his leadership on this issue.

He is right. There are only nine women in the Senate. We shouldn't have to rush to the floor to defend all of the women in this country every time an issue comes up that affects women's health. This is an issue that affects men as well. It affects their daughters, their wives and mothers, their aunts. I appreciate Senator ROBB and his leadership in making sure that women are protected when it comes to their health care.

Senator ROBB did an excellent job of outlining what our amendment does. It does two basic things:

It allows a woman the right to choose an OB/GYN as her primary care physician. As every woman in this country knows, their OB/GYN, their obstetrician/gynecologist, is the doctor they go to, whether it is for pregnancy, whether it is for breast cancer, whether it is for health care decisions that affect them later on in life. We want to make sure that women have access to those doctors without having to go back to a primary care physician.

When a woman is pregnant and she gets an ear infection, she may be treated dramatically different than someone

else who has an ear infection, for example. A woman needs to have access to the OB/GYN, and this amendment Senator ROBB and I and the other Democratic women are offering assures the woman that access.

Secondly, it deals with the so-called drive-through mastectomy legislation where too many HMOs today are telling a woman after this radical surgery—

The PRESIDING OFFICER. The time of the Senator has expired.

Mrs. MURRAY. I ask unanimous consent for an additional 30 seconds.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mrs. MURRAY. Too many women today are told they need to go home before they are ready to take care of themselves or their families. This amendment doesn't designate a time. It says the doctor will determine whether that woman is ready to go home after this radical surgery.

I commend my colleagues for this issue. I urge the Members of the Senate to stand up, finally, for women's health and vote for this amendment.

The PRESIDING OFFICER. The Chair recognizes the Senator from Maryland.

Ms. MIKULSKI. I thank the Chair.

Mr. President, I thank Senator Robb and Senator KENNEDY for their support of this very crucial legislation. We, the women of the Senate, really turn to men we call the "Galahads," who have stood with us and been advocates on very important issues concerning women's health.

Often we have had bipartisan support. I ask today that the good men on the other side of the aisle come together and support the ROBB amendment. We have raced for the cure together. We have done it on a bipartisan basis. Certainly, today we could pass this amendment. I challenge the other party to vote for this amendment because what it will do is absolutely save lives and save misery.

There are many things that a woman faces in her life, but one of the most terrible things that she fears is that she will go to visit her doctor and find out from her mammogram and her physician that she has breast cancer. The worst thing after that is that she needs a mastectomy. Make no mistake, a mastectomy is an amputation, and it has all of the horrible, terrible consequences of having an amputation. Therefore, when the woman is told she can come in and only stay a few hours—after this significant surgery that changes her body, changes the relationships in her family, she is told she is supposed to call a cab and go back home; it only adds to the trauma for her.

Well, the ROBB amendment, which many of us support, really says that it is the doctor and the patient that decides how long a woman should stay in the hospital after she has had the surgery. Certainly, we should leave this to the doctor and to the patient. An 80

year old is different than a 38 year old. This legislation parallels the D'AMATO legislation that had such tremendous support on both sides of the aisle. I say to my colleagues, if we are going to race for the cure, let's race to support this amendment.

Mr. REID addressed the Chair.

The PRESIDING OFFICER. The Senator from Nevada is recognized.

Mr. REID. Mr. President, Senator BYRD is on his way here. He has asked for 1 minute. If the Senator from Oklahoma would indulge me, he should be here momentarily. I ask unanimous consent that Senator BYRD be entitled to 1 minute when he gets here, which should be momentarily.

The PRESIDING OFFICER. Is there objection?

Without objection, it is so ordered.

Mr. BYRD addressed the Chair.

The PRESIDING OFFICER. The Chair recognizes the Senator from West Virginia.

Mr. BYRD. Mr. President, how much time remains before the recess?

The PRESIDING OFFICER. The unanimous consent allows 1 minute.

Mr. BYRD. Mr. President, I ask unanimous consent that I may speak for not to exceed 3 minutes.

The PRESIDING OFFICER. Is there objection?

Without objection, it is so ordered.

Mr. BYRD. Mr. President, I am pleased that the Senate is finally considering managed care reform legislation. I believe that the Democratic version of the Patients' Bill of Rights is the right vehicle on which to bring reform to the nation.

Our colleague from Virginia, Mr. ROBB, has offered an amendment that highlights an important aspect of managed care that needs to be fine-tuned, and that is women's access to health care. This amendment would allow a woman to designate her obstetrician/gynecologist (ob/gyn) as her primary care provider and to seek care from her ob/gyn without needing to get preauthorization from the plan or from her primary care provider. Even though many women consider their ob/gyn as their regular doctor, a number of plans require women to first see their primary care provider before seeing their ob/gyn. This means that a costly and potentially dangerous level of delay is built into the system for women. This amendment would allow a woman's ob/gyn to refer her to other specialists and order tests without jumping through the additional hoop of visiting the general practitioner.

This amendment would also address the care a woman receives when undergoing the traumatic surgery of mastectomy. This provision would leave the decision about how long a woman would stay in the hospital following a mastectomy up to the physician and the woman. Some plans have required that this major surgery be done on an outpatient basis. In other instances, women have been sent home shortly after the procedure with tubes still in

their bodies and still feeling the effects of anesthesia. This should not be allowed to happen. Plans should not put concern about costs before the well-being of women.

The Republican bill does not provide women with sufficient access to care. Plans would not be required to allow women to choose their ob/gyn as their primary care provider. In addition, the Republican bill would allow health plans to limit women's direct access to her ob/gyn to routine care which could potentially be defined by a plan as one visit a year. In addition, "drive-through mastectomies" would not be prevented under their bill.

Mr. President, the Robb amendment contains commonsense protections women need and deserve. I urge my colleagues to support this important amendment.

I yield the floor.

# RECESS

The PRESIDING OFFICER. Under the previous order, the hour of 12:30 having arrived, the Senate will now stand in recess until the hour of 2:15 p.m.

Thereupon, the Senate, at 12:36 p.m., recessed until 2:16 p.m.; whereupon the Senate reassembled when called to order by the Presiding Officer (Mr. BENNETT).

The PRESIDING OFFICER. Under the previous order, the Senator from New Hampshire is recognized to speak for up to 45 minutes.

Mr. LOTT. Mr. President, I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The legislative assistant proceeded to call the roll.

Mr. SMITH of New Hampshire. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. SMITH of New Hampshire. Mr. President, I ask I be recognized for a period of time, approximately 45 minutes.

The PRESIDING OFFICER. Under the order, the Senator from New Hampshire is recognized for 45 minutes.

# LEAVING THE REPUBLICAN PARTY, A DECISION OF CONSCIENCE

Mr. SMITH of New Hampshire. Mr. President, as many of you know, it has been a very difficult period of time for me these past several days. I want to recognize the sacrifices of my wife and three children over the past several weeks as I agonized through this gut-wrenching political decision. My wife, Mary Jo, and my daughter, Jenny, and son, Bobby, and son, Jason, have had to endure the ups and the downs and the difficulties of making such a decision. I am deeply grateful to them for their support and comfort because, without